Health Information and Quality Authority
Social Services Inspectorate

Regulatory Monitoring Visit Report
Designated centres for older people

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	Owen Riff Nursing Home
Centre ID:	0375
Centre address:	Camp Street Oughterard, Co Galway
Telephone number:	091 866946
Fax number:	N/A
Email address:	owenriff@eircom.net
Type of centre:	☒ Private ☐ Voluntary ☐ Public
Registered providers:	Riverside Nursing Home Ltd
Person in charge:	Grace Kelly
Date of inspection:	20 and 21 April 2012
Time inspection took place:	**Day-1 Start:** 09:30 hrs **Completion:** 18:20 hrs **Day-2 Start:** 10:00 hrs **Completion:** 14:00 hrs
Lead inspector:	Fiona Whyte
Support inspector:	Carol Grogan
Type of inspection:	☐ Announced ☒ Unannounced
Purpose of this inspection visit:	☐ Application to vary registration conditions ☐ Notification of a significant incident or event ☐ Notification of a change in circumstance ☐ Information received in relation to a complaint or concern ☒ Regulatory Monitoring Visit Report

About the inspection

The purpose of inspection is to gather evidence on which to make judgments about the fitness of the registered provider and to report on the quality of the service. This is to ensure that providers are complying with the requirements and conditions of their registration and meet the Standards, that they have systems in place to both safeguard the welfare of service users and to provide information and evidence of good and poor practice.

In assessing the overall quality of the service provided, inspectors examine how well the provider has met the requirements of the Health Act 2007, the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) and the *National Quality Standards for Residential Care Settings for Older People in Ireland*.

Additional inspections take place under the following circumstances:

- to follow up on specific matters arising from a previous inspection to ensure that the action required of the provider has been taken
- following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Social Services Inspectorate that a provider has appointed a new person in charge
- arising from a number of events including information received in relation to a concern/complaint or notification to the SSI of a significant event affecting the safety or wellbeing of residents
- for centres that have not previously been inspected within a specific timeframe, a one-day regulatory monitoring visit may be carried out to focus on key regulatory requirements.

All inspections can be announced or unannounced, depending on the reason for the inspection and may take place at any time of day or night.

All inspection reports produced by the Health Information and Quality Authority will be published. However, in cases where legal or enforcement activity may arise from the findings of an inspection, the publication of a report will be delayed until that activity is resolved. The reason for this is that the publication of a report may prejudice any proceedings by putting evidence into the public domain.

About the centre

Description of services and premises

Owen Riff Nursing Home is a two-storey, purpose-built centre which opened in 2003. It is a family run business and there are places for 40 residents. At this inspection, there were 22 residents receiving long-term care. Some of these residents had a cognitive impairment and dementia related conditions.

The entrance door leads to a reception area and the nurses' station is located opposite the reception desk. Communal accommodation includes a dining room and small day room on the ground floor. While there is another day room, oratory and recreational room on the first floor, these were not in use at the time of inspection. There is a smoking room which is also used as the hairdressing room. The kitchen, a wash-up area and a food storage room are adjacent to the dining room on the ground floor. The catering staff toilet and laundry room are located in this vicinity. There are two sluice rooms, one on each floor of the building.

There are 35 bedrooms in total, 30 single bedrooms and five twin bedrooms. Fourteen single bedrooms and five twin rooms are located on the first floor with the remaining 16 single bedrooms on the ground floor. One twin room has an en suite assisted bath, toilet and hand-washing facilities while the remaining four twin rooms have en suite assisted shower, toilet and hand-washing facilities. The single bedrooms have an en suite toilet and hand-washing facilities. There are four assisted bathrooms - two on the first floor with bath, toilet and hand-washing facilities and two on the ground floor, one with bath and shower and the second with assisted shower, toilet and hand-washing facilities. At the time of this inspection one bathroom on the first floor was not in use due to refurbishment works which had commenced. The works were partially completed and inspectors noted that no work was carried out during the inspection.

Staff changing facilities are on the first floor and a designated toilet for non-catering staff is provided in this facility. A separate residents' toilet and visitors' toilet are located on each floor. There is a wheelchair accessible visitors' toilet on the first floor.

There is a passenger lift servicing the floors. Car parking for relatives, staff and visitors is available to the front of the building. There is no secure garden for use by residents.

Location

Owen Riff Nursing Home is located in Oughterard, County Galway and is approximately 26 kilometres from Galway City. It is within walking distance of local shops and amenities.

Date centre was first established:	2003
Number of residents on the date of inspection:	22
Number of vacancies on the date of inspection:	18*

* 10 of these beds were subject to the conditions of registration.

Dependency level of current residents*	**Max**	**High**	**Medium**	**Low**
Number of residents	4	11	4	3

* As provided by the person in charge on 20 April 2012.

Management structure

Owen Riff Nursing Home is owned by a limited company, Riverside Nursing Home Ltd. One of the Directors, Theresa O'Toole is the named person to act on behalf of the Provider. The Person in Charge is Grace Kelly and she reports directly to the Provider. Nurses and care assistants report to the Person in Charge. Catering and cleaning staff report to the Provider or the Person in Charge. Maintenance work is the responsibility of Kevin O'Toole, the Provider's husband. There is also a personal assistant to the Provider and an accountant both reporting to the Provider.

Staff designation	**Person in Charge**	**Nurses**	**Care staff**	**Catering staff**	**Cleaning and laundry staff**	**Admin staff**	**Other staff**
Number of staff on duty on day of inspection	1*	1** x 8 - 2 agency nurse	2 1 x 3 - 5 for activities	1	1 x 10 - 3 (cleaner) Care staff do laundry duties	1	2***

* The person in charge was on duty from 9.00 am to 2.00 pm and was the nurse on duty from 2.00 pm to 8.00 pm.
** The nurse on duty from 8.00 am to 2.00 pm was an agency nurse and had never worked in the centre before.
*** The provider and the provider's husband attended the centre during the inspection.

Summary of findings from this inspection

Owen Riff Nursing Home was inspected by the Health Information and Quality Authority (the Authority) Social Services Inspectorate on 3 and 4 June 2010. It was an announced registration inspection. The provider had applied for registration under the Health Act 2007 (Registration of Designated Centres for Older People) Regulations 2009 and the Health Act 2007 (Care and Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended). Registration was granted for 40 places, subject to specific conditions including the requirement to obtain prior written agreement from the Chief Inspector before increasing the number of residents over 30. The provider had since applied to remove the conditions.

A full inspection was carried out on 14 March 2012 to monitor compliance with the Regulations and the *National Quality Standards for Residential Care Settings for Older People in Ireland* and make a recommendation to the Chief Inspector regarding the provider's application to remove the conditions. Inspectors assessed the provider's application under areas such as governance, staffing, quality of life and healthcare. Inspectors met with the newly appointed person in charge who had predominantly worked on night duty in the centre from 2005.

During the inspection of 14 March 2012, there were 44 actions identified as being required to bring the centre into compliance with the Regulations and Standards. Significant improvements required included the provision of mandatory fire safety training and moving and handling training. Training was also required in areas such as protection of vulnerable adults and medication management. Significant improvements were also required in medication management processes and practices, risk management, staff files, access to allied health services and assessment and care planning.

Inspectors were not satisfied that there were sufficient staffing levels and skill-mix on duty and the provider was required to review the staffing levels to ensure that the needs of residents were met.

During the inspection eight specific environmental risk issues were identified and 11 specific issues in relation to medication management were identified as posing a risk and the provider was required to immediately address them. The regulatory failings and the actions to be undertaken were detailed to the provider and the person in charge during the inspection and in the report of the inspection issued to the provider on 19 March 2012. The action plan returned by the provider on 3 April 2012 was inadequate in that it did not outline what actions the provider had taken or intended to take to address all the requirements to ensure that residents were safe and to bring the centre into compliance with the Regulations and the Standards.

This inspection of 20 and 21 April 2012 was an unannounced monitoring inspection. It was carried out to follow up on the specific risk issues arising from the previous inspection, to ensure that the action required of the provider had been taken and that residents were safe. The issues focussed on included but were not limited to:

- risk management
- medication management
- healthcare provision
- nursing documentation
- staffing levels.

As part of the inspection the inspectors met with residents and staff members. Inspectors observed practices and reviewed documentation such as resident care plans, medical records, incident and accident logs, medication management, risk management, staff rosters and staff files.

Inspectors were not satisfied that the provider and person in charge had taken the necessary actions to address the failings as identified in the report of the inspection of 14 March 2012 which resulted in ongoing risk to residents. The inspectors met with the provider on day-one of the inspection to discuss concerns regarding the ongoing non-compliance with the Regulations and Standards. A letter was also hand-delivered to the provider reminding it of its obligations under the Health Act, 2007 (as amended), the Regulations and Standards.

Inspectors were significantly concerned during this inspection that many of the risk issues had not been addressed. Of the eight specific environmental risk issues identified for immediate action only one had been addressed and of the 11 specific issues identified for immediate action in relation to medication management none had been addressed. Other healthcare issues identified at the previous inspection such as management of nutrition and weight loss, falls management, wound management and access and referral to allied health professionals remained a significant concern. The staffing levels had further decreased since the previous inspection and remained very concerning. Due to these significant concerns an immediate action plan was hand delivered to the provider and person in charge on the morning of 21 April 2012. This action plan included a requirement for immediate action on the following areas:

- risk management
- medication management
- staffing
- provision of a high standard of evidence-based nursing practice
- assessment and care planning.

The person in charge was also required to undertake an investigation into medication errors noted in the Register of Controlled Drugs.

A request was also made to the provider to cease admissions on the morning from 21 April 2012.

On 27 April 2012, due to the serious issues identified and pursuant to Sections 59 and 60 of the Health Act, 2007 (as amended), an Ex Parte Interim Order was made by Galway District Court, inter alia, cancelling the registration of Owen Riff Nursing Home, Camp Street, Oughterard, Co. Galway as a designated centre under Part 8 of the Health Act, 2007. In accordance with Section 64 of the Health Act, 2007, the Health Service Executive (HSE) was directed to make alternative arrangements for the residents of Owen Riff Nursing Home as soon as practicable.

On 30 April 2012, in the High Court, it was agreed between all parties that those parts of the Order of the District Court were suspended pending further order of the District Court.

On 4 July 2012, Galway District Court determined the matters dealt with in the Ex Parte Interim Order of 27 April 2012 and confirmed that Ex Parte Interim Order which, among other things, cancelled the registration of Owen Riff Nursing Home. The registered provider appealed that final determination to the Circuit Court.
On 31 July 2012, at the Circuit Court, sitting in Galway, the registered provider of Owen Riff Nursing Home withdrew its appeal and the Circuit Court confirmed the Order of the District Court.

In accordance with Section 64 of the Health Act, 2007, the HSE was, pursuant to the Order of the District Court, directed to take charge of Owen Riff Nursing Home and to make alternative arrangements for the residents of Owen Riff Nursing Home as soon as practicable.

As the registration of this centre is now cancelled there is no Action Plan at the end of this report.

Governance

Article 5: Statement of Purpose

At the previous inspection the statement of purpose was not in compliance with the Regulations. The provider was required to update the statement of purpose and submit it to the Authority. To date this has not been received.

Article 15: Person in Charge

At the previous inspection the person in charge was in post two days. This was not notified to the Chief Inspection by the provider and as a result a fit person interview had not been arranged. The person in charge subsequently underwent the fit person interview on 13 April 2012.

Inspectors had significant concerns in relation to the fitness of the person in charge. While the person in charge met the specific requirements of the Regulations, she did not demonstrate strong leadership skills. Since 2005 she had engaged in limited continuous professional development, and training was not yet prioritised or identified for her. Prior to taking up her current post her previous role was that of the nurse in charge on night duty in the centre since 2005. While she was the named person to deputise for the previous person in charge she stated that when she deputised it was an on-call arrangement and she was not actually present in the centre. This meant that she did not have the necessary experience to undertake the clinical and managerial responsibilities of the person in charge.

The person in charge confirmed that she had input into the completion of the action plan specifically relating to the clinical actions required. She indicated that since the previous inspection she had focused on individualising and reviewing resident's care plans. She stated she had addressed gaps identified and was updating all care plans. There was no evidence to support this statement at the inspection.

She stated she was satisfied with the current staffing levels and felt there was adequate supervision of staff and residents despite this being raised as a significant concern at the previous inspection and despite the person in charge being rostered as the nurse on duty for many shifts due to staff shortages.

Inspectors found the person in charge to be disorganised and they had difficulty getting information in a timely manner when requested. The nursing documentation was found to be out of date, disorganised and in some cases not relevant to the current status of the resident. Information was located in various files and in different locations. In some cases residents had two files with similar information and staff were unaware of which file was current.

Article 16: Staffing

Inspectors continued to be gravely concerned that the staffing levels and skill-mix remained inadequate to meet the needs of the residents and ensure their safety.

On arrival at the centre many residents were still in bed. The atmosphere in the centre was subdued with six residents in the day room either asleep or looking at the TV. Staff appeared hurried with no time for conversation with residents. Some residents were noted to be in bed very late in the morning, one resident was seen having his breakfast at the dinner table at 11.40 am, he was left at the table and remained there until his dinner was served at 12.30 pm.

Throughout the inspection residents were noted to be unkempt and their hair not brushed or combed. Some residents' clothes were not ironed while many residents' clothes were dirty. Residents' finger nails were not cared for and required cleaning and trimming. Male residents were unshaved. There was a 'bowel/shower' book in use, this indicated that the majority of residents did not have a bath or shower in the previous month instead 'sponge' was recorded.

Some staff were out on long-term sick leave and one nurse had left the service since the previous inspection. There were two care assistants on duty and one agency nurse on the day of inspection. The person in charge confirmed the reduction in staffing levels and confirmed that often she was the nurse on duty as well as the person in charge. She confirmed that there were now only 2.46 whole time equilivant (WTE) nurses employed in the centre in addition to the person in charge. There was also only 6.83 WTE care assistants employed in the centre. The laundry duties were carried out by the care assistants. These staffing levels were for 30 residents. The provider confirmed that she had difficulty recruiting staff and stated that getting staff to work in the centre was very difficult. As a result there was considerable reliance on agency staff. In some instances the agency staffs had never worked in the centre previously and so were not familiar with the building, the residents, the care processes and the medications. The agency staff had also not received any orientation, induction or briefing on fire safety and evacuation procedures prior to working in the centre or during their shift. Inspectors noted that the agency nurse was administering medications up to 10.30 am in the mornings because she was unfamiliar with the residents and their medications.

The roster showed that on the previous Saturday 14 April 2012, the nurse rostered on night duty the previous evening worked from 8.00 pm to 10.00 am the next morning. An agency nurse was also rostered on duty that day from 8.00 am to 8.00 pm. When questioned as to why there was a requirement for two nurses to be on duty from 8.00 am to 10.00 am that morning the provider and person in charge did not give any reason but stated that the roster was correct. Inspectors requested verification of this by way of a copy of the salary returns to verify the roster, the provider said that this was not available. Inspectors then requested the provider ask the agency to verify by faxing a copy of the hours claimed for that day. The provider then stated that the agency nurse had not turned up that Saturday and the nurse rostered on night duty provided an additional two hours cover that morning up to 10.00 am. This meant that the nurse on night duty had worked 14 hours without a

break. The provider also confirmed that there was no nurse on duty in the centre from 10.00 am to 2.00 pm. This information was provided to the inspectors four hours after it was requested.

The rosters were viewed and showed that the additional 8.00 pm to 10.00 pm shift agreed previously by the provider following the inspection of August 2011 was not consistently covered on a daily basis. Staff were seen to be hurried, with no time to communicate with each other or with residents. Staff were standing over residents while assisting to eat and many residents were in bed far longer than they should have been. One staff member, observed standing over a resident while assisting him to eat, was asked by an inspector to sit with the resident, the staff member stated she did not have time. Some residents were receiving their breakfast when it was almost dinner time. One resident was noted sitting in the dining room calling for assistance, there was no staff member to respond. This resident was unkempt, unshaven and his eyes were crusted and sore. This was brought to the attention of the person in charge who said she hadn't yet had time to deal with some issues.

The chef had left since the previous inspection and a new chef was in post a few days. She stated she had received one day's induction. She was not aware of residents' specific dietary needs and could not locate documentation to show the specific dietary needs of residents. She had not received moving and handling training or elder abuse training.

On the second day of inspection fire training was in progress. The nurse on duty was in attendance at this fire training as well as one care assistant also rostered on duty. The provider and the person in charge were also attending fire training. This meant that there was one care assistant on duty to provide care for 22 residents. The personal assistant to the provider was undertaking some duties such as supervising the residents in the day room. The nurse had to drop in and out of the fire training during the day to administer medications.

Staff files were checked as this was an action the provider had stated was addressed in the action plan of 14 March 2012. The action was not addressed and the files still did not contain the required information such as Garda Síochána vetting, three references and evidence of medical and physical fitness.

There was no evidence to show that provision of education and training for staff was prioritised. There was still no clinical education scheduled to ensure contemporary evidence base care was delivered. There was no evidence that staff were supervised pertinent to their roles.

Article 31: Risk Management Procedures

Inspectors found that practice in relation to the health and safety and the management of risk did not promote the safety of residents, staff and visitors.

Very significant environmental risks were identified at the inspection of 14 March 2012 which required immediate action. These issues were not addressed in the action plan submitted by the provider. The provider stated in the action plan that a staff member was appointed as 'project supervisor' and had responsibility for addressing all of the environmental issues. At the inspection of 20 and 21 April 2012 these issues were checked and it was noted that only one issue was addressed. Additional issues were also identified.

Some of the hot water to wash-hand basins was scalding to the touch.
This issue was unchanged and additional issues identified. During this inspection the hot water was again scalding to the touch in some sinks on the ground floor while in some bedrooms on the first floor the water was cold. The water temperature was checked by inspectors and recorded in three sinks at various locations as 45.1, 47.6 and 48.1 degrees Celsius.

Doors within the centre had a key-pad locking system. However, the inspectors noted that two doors from the first floor to ground floor were not secure and provided direct access onto stairs posing a serious risk to residents.
This issue was addressed and the doors remained secured during the inspection.

Cleaning chemicals were noted to be stored in the laundry, on trolleys in corridors and in some toilets which posed a risk to residents.
This issue remained unchanged. Cleaning agents and chemicals were still stored unsecured in bathrooms, on trolleys and in the laundry.

A trolley on one corridor was unattended and was seen to contain scissors, equipment for repair and maintenance purposes such as screwdrivers, topical medication and unlabelled cleaning chemicals.
This trolley no longer contained the topical medication or maintenance equipment. However, there were two trolleys noted unattended, one on the ground floor and another on the first floor, each contained items such as unlabelled chemicals, yogurts, clean bed sheets, continence wear and gloves. Maintenance equipment such as screw drivers were now noted to be stored in the sluice room which was open and easily accessible to residents.

The doors to the sluice rooms were left open, as was the laundry room. They were unattended at the time and so posed a risk to residents.
This action was not addressed and the risk remained the same.

The laundry was used to store general equipment and cleaning equipment including mops which were stored in mop buckets filled with dirty water. This practice posed an infection control risk.
This was unchanged. On the first day of inspection the laundry room was very disorganised and dirty. Cleaning equipment, chemicals and disinfectants and a blood spill kit was still being stored there. There was no area for segregating clean and soiled clothing. Cleaning mops were standing in buckets of water. On the second day of inspection a trolley was stored in the laundry room with continence wear, gloves, clean underwear and a dirty toilet brush.

The sink in the laundry was being used by the cleaners to empty and fill their cleaning buckets posing a risk of infection.
Inspectors saw the cleaner empty dirty cleaning water into the laundry sink while clothes were steeping in the sink. When questioned he did not know correct procedures to prevent cross infection.

A raised electrical socket was noted in the middle of the kitchen floor posing a risk of falls.
This was unchanged and remained a risk.

Additional issues noted at this inspection are detailed below.

Under all the stairs in the building there was storage of equipment such as maintenance supplies and equipment, paint, hairdressing items, mattresses, black plastic bags of clothes and wheelchairs. A clinical waste bin was located under one of the stairs, it was not locked and easy accessible to residents.

One resident was noted smoking in his bedroom. There was no risk assessment undertaken to ensure his and other residents safety.

One resident's bedroom was notably very cold. The resident stated he felt cold and did not want to get up as a result. Staff said that this had been an issue and they did not know why the room was cold. This issue was brought to the attention of the provider and the person in charge who acknowledged that they were aware of the issue but had not addressed it. They were asked to address the issue as a matter of urgency for this resident. The inspectors noted that the room was warmer on day-two of the inspection.

Infection control issues were not addressed and additional issues were noted at this inspection. For example:

- Open black bags and bins were being used by staff for the disposal of soiled continence wear. Inspectors could clearly see and smell the continence wear soiled with faeces. As these bags were left unattended and accessible on corridors they posed an infection control risk.

- the wheelchair accessible toilet at the front of the building was very dirty. There was a plunger on the floor and a raised toilet seat also on the floor. Several bottles of cleaning chemicals were also stored here.

The risk management policy still did not identify the specific environmental risks associated with this centre and the emergency plan had not been updated to provide guidance to staff on specific emergencies that might occur within the centre.

Mandatory training had still not been provided or scheduled for all staff. There were still no comprehensive training records maintained to show what training had been provided and what training was due. Moving and handling training had not been provided or scheduled since the previous inspection therefore all staff had not received mandatory training. Staff were seen to carry out unsafe manual handling practices. Two staff members, a care assistant and the personal assistant to the provider were seen to carry out a full underarm lift with a resident from a wheelchair to a chair in the day room. The staff nurse was then observed bringing in this residents Zimmer frame after the lift was completed.

Inspectors were not satisfied that the quality of care and experience of the residents were monitored and developed on an ongoing basis. There was evidence that certain quality indicators had been gathered by the previous person in charge but it appeared that this had lapsed and was not maintained to inform practice. The person in charge did not have systems in place to gather and audit information to identify possible trends and for the purpose of improving the quality of service and safety of residents. There was no auditing of information on accidents and incidents. There were 11 falls recorded from 1 January 2012 to 21 April 2012. The information recorded for each fall still did not include any additional action taken following the fall including any measures put in place to minimise the risk of reoccurrence.

Resident Care

Article 9: Health Care

The inspectors continued to be critically concerned that the care delivered to residents was not evidence-based and of a high standard. Improvements were still also required around the provision of meaningful engagement for all residents.

There was still no evidence that residents had a medical review carried out or their medications comprehensively reviewed since the previous inspection or that this was planned.

There was still limited access to allied health professionals. No residents had been referred to physiotherapy, dietetic or speech and language services (SALT). The provider had still not investigated other options such as access to private dietetics or SALT. One resident identified at the previous inspection that appeared to be seated very uncomfortably in her chair and falling to one side was referred to a private occupational therapist (OT) for seating assessment.

The nursing documentation and care planning systems were very inadequate. The person in charge had told inspectors she had been updating the residents' care plans since the previous inspection. The inspectors reviewed a number of residents' files and noted that many of the files had "R/V" and a date inserted to denote a review. However, assessments were not updated and as a result the evaluation of care interventions was not accurate. There was no updated information recorded to show what had been reviewed and what changes if any were required. Therefore the care plans were not reflective of the residents' current condition or needs. There was an absence of accurate nursing documentation by which to guide the care interventions and because there was an over reliance on agency staff in the centre there was poor continuity and fragmentation of care.

Inspectors examined the files of residents reviewed at the previous inspection and some additional residents' files. The same inconsistencies in the nursing documentation were again identified. There was no comprehensive nursing assessment carried out for any resident. Risk assessments were either not carried out or were out of date. Care plans were either not in place or out of date. Care plans for specific medical conditions were not in place.

Residents who had a fall were still not routinely referred to the GP for review. Falls reassessment was not undertaken following a fall and measures to be put in place were not documented. Care plans were not in place or were not updated following a fall. One resident sustained four falls, two resulting in head injuries. No up-to-date falls assessment was completed and there was no care plan or interventions put in place. Another resident sustained two falls and again no up-to-date assessment was carried out and no care plan or interventions were put in place.

Inspectors were seriously concerned that residents at risk of malnutrition were not managed appropriately. The nutrition policy in place did not inform practice. The person in charge had identified a number of residents at risk of losing weight on the morning of 20 April 2012. However, when these residents' care plans were reviewed there was limited or no information available to indicate that staff were aware of these residents at risk or had implemented appropriate actions to manage the risk. Residents' weights were still not recorded on a consistent and regular basis and in some cases there were no weights recorded. Again inspectors found it difficult to determine whether any residents had any significant weight loss. Nutritional assessments were either not undertaken or were not up to date. There were no appropriate care plans in place. Some residents had specific dietary requirements, however, the care assistants and the agency nurse on duty were not able to tell inspectors of their specific needs. The main meal was noted to be served on side plates for some residents. This was highlighted to the person in charge and the provider. However, no action was taken and the portions remained very small again on the second day of inspection.

There was no improvement in relation to the use of restraint. Assessments were not undertaken and care plans were not in place. Alternatives were not considered and release charts were not in use. Practice in relation to the use of restraint required improvement. Residents who were agitated were prescribed chemical restraint and again alternatives were not tried prior to the use of chemical restraint.

At this inspection the person in charge told inspectors that there were two residents with pressure ulcers. However, the wound care folder indicated that there were five residents with wounds/pressure ulcers. It was difficult to ascertain from the documentation exactly which residents had wounds and how many wounds each resident had. The 'wound progress plan' in place noted general changes at the time of dressing change but again contained insufficient detail to allow staff to track the progress of the wound. Some residents were on pressure relieving mattresses and again these were noted to be set incorrectly thus posing an increased risk to residents. Repositioning charts were in some residents' bedrooms, however, they were not maintained up to date.

Some residents were prescribed analgesia for pain management. There were no up-to-date pain assessments carried out and no care plans in place for these residents.

There appeared to be a poor quality of life for the residents in the centre and activity provision was very poor. Residents' bedrooms were sparsely decorated, with many having no pictures, photographs or personal mementos. On the first day of inspection a care assistant was supervising residents in the day room while on the second day of inspection the personal assistant to the provider was supervising residents. There was no interaction or conversation between these staff members and the residents and no stimulation or activities going on during the days. The person in charge stated that the activities coordinator was on sick leave for a number of weeks. A care assistant was assigned to provide activities from 2.00 pm to 3.00 pm daily. However, little was noted to be going on. The care assistant stated that they usually played bingo but many of the residents were too tired to partake in activities. She was noted to sit in the day room without interacting with residents or providing activities. There was no senior staff member available to provide direction

to these staff members. Many residents were isolated in their bedrooms with no interaction or conversation for very long periods of time during the day.

Some practices in place were institutional and undignified for residents. For example, communal creams were noted to be in use such as sudocream.

The inspectors were so concerned in relation to the standard of care to residents that the provider was asked on 21 April 2012, to consent to the agents of the Health Service Executive (HSE) carrying out clinical assessments on the residents.

Article 33: Ordering, Prescribing, Storing and Administration of Medicines

Inspectors continued to have significant concerns around the medication management practices as the majority of the issues identified in the previous inspection were not addressed. The provider had stated in the action plan response that this action had been completed. Additional issues were identified at this inspection including a number of medication errors which posed a risk to the safety of the residents.

One inspector joined the agency nurse on the medication round. The agency nurse had a list of all the residents and the room numbers to aid her in identification purposes. It was 10.30 am when the inspector joined the agency nurse who was still administering medications that were prescribed to be administered at 8.00 am. When asked how she identified the right resident for the right medication she stated that because she had never been in the centre before she was relying on the list of residents she was given to be correct and accurate. She had not been made aware that there was a resident photograph on the 'rack' of medications which she could have referred to. However, not all the residents had a photograph on the 'rack'.

The register of controlled drugs (MDA) was reviewed and a number of issues identified. The medication management policy and An Bord Guidelines required the signature of two staff members "given by" and "checked by" when administering MDA medication. Inspectors noted several errors which posed a risk to residents for example:

- medications were not consistency "checked by" a second person
- on a number of occasions the MDA count and recorded balance was incorrect with no explanation recorded
- in addition, during the inspection the room where the controlled drug press was located was found to be open and the controlled drug press itself unlocked. This was immediately brought to the attention of the person in charge who addressed the issue.

The inconsistencies in the register of controlled drugs were also brought to the attention of the person in charge at 11.00 am on 20 April 2012 and she was requested to conduct an immediate investigation into the irregularities in the register. An immediate action plan was issued by hand to the provider and person in charge on 21 April 2012 and in electronic format 23 April 2012 which included the requirement to carry out an investigation into the matter immediately. The

completed investigation was to be submitted to the Authority on 25 April 2012, this was not submitted.

On reviewing the medication prescribing and administration charts a number of medication errors were also noted, for example:

- some residents prescribed medications with a specific finish date were not always discontinued/finished on that date but continued to be administered by nursing staff
- some residents prescribed regular medications were not administered these medications in accordance with the daily prescribing times
- the agency nurse identified that three residents required crushed medications yet this was not prescribed.

The person in charge was not aware of the number of medication errors occurring in the centre. She had stated to inspectors that there were no medication errors. The policy for medication management indicated that there was a system in place for reporting medication errors. However, none of the nurses including the person in charge were able to identify what a medication error was, how to manage and report medication errors and how to put systems in place to reduce the number of errors and maintain residents' safety.

The transcribing of medications was still not in line with the policy or the relevant professional guidelines. Transcribed medications were still not individually signed by the transcribing nurse and witnessed and signed by the second nurse. Considering the number of medication errors noted in the administration of medications, the inspectors were extremely concerned regarding this practice. The lack of safe practices regarding the transcribing of medications was highlighted to the provider and person in charge in the inspection report of 14 March 2012.

Training records were not available to show that medication management refresher training had been provided to all nursing staff.

Article 6: General Welfare and Protection

Improvements were required to ensure evidence-based nursing practice was provided and to ensure residents were protected from being harmed or suffering abuse.

The centre's policy on the prevention, detection and response to elder abuse had not been updated from the previous inspection and remained inadequate.

There were still no comprehensive training records maintained to show that staff had received training in the prevention, detection and management of elder abuse. Some staff confirmed that they had not received training and some staff were unsure of what to do if an allegation of abuse was made to them.

Article 20: Food and Nutrition

Inspectors were concerned regarding the portion size of the meals. Some residents were seen having dinner (main meal approximately 1.00 pm) on side plates. This was brought to the attention of the provider and person in charge on the first day of inspection however no action was taken and the situation remained unchanged on the second day of inspection.

Water and drinks were not freely available or easily accessible to residents. Dependent residents isolated in bedrooms had no access to fluids.

Residents who required modified consistency meals were presented with all the ingredients mixed together in a bowl. The meal was of a brown colour and was unappetising and unappealing for anyone.

Staff were seen standing over the residents who required assistance with their meals, thus increasing the risk of swallow difficulties. It was also undignified for the residents to have a staff member stand over them rather than sitting at eye level and making the meal an enjoyable social occasion.

When speaking with the chef she had not been made aware of one resident's requirement for a specialised diet due to a complex medical condition. The agency nurse on duty and a care assistant were also unaware of this resident's specific dietary needs which posed a risk to the resident. The information they provided to the inspector was at complete contrast with the strict requirements of his dietary needs.

Environment

Article 19: Premises

A number of issues identified at the previous inspection had not been addressed and remained a concern. In addition other issues were identified at this inspection.

One bathroom was noted now to be out of order. Staff said it was out of order for four weeks. There was refurbishment work ongoing, however, at the time of inspection this work had ceased and the shower room could not be used.

No essential maintenance work had been carried out in the building since the previous inspection. Some areas of the building not in use were still not clean and well maintained. The water damage to ceilings and walls on all both floors remained unchanged.

The wheel on the hoist was still not repaired. This was a required action from the inspection of 14 March 2012. The provider had stated at that inspection that ‘a replacement wheel was on order and the hoist would be repaired shortly’, however, this was not done.

The smoking room was still being used as the hairdressing room. The ventilation was inadequate as highlighted at the previous inspection.

Storage facilities for all equipment and supplies were still inadequate.

There was still no safe and secure garden accessible to residents.

Article 32: Fire Precautions and Records

Fire safety training had been provided the previous week and a second training session was provided during the inspection on 21 April 2012. The provider stated that all staff would be then trained in fire safety with the exception of one staff member who was on sick leave.

Closing the visit

At the close of the inspection on the first day 20 April 2012 a feedback meeting was held with the provider and person in charge to report on the inspectors' findings, which highlighted the areas of serious risk and where significant improvements were needed. An additional feedback meeting was held on 21 April 2012 and the provider, person in charge and the provider's husband attended this meeting.

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